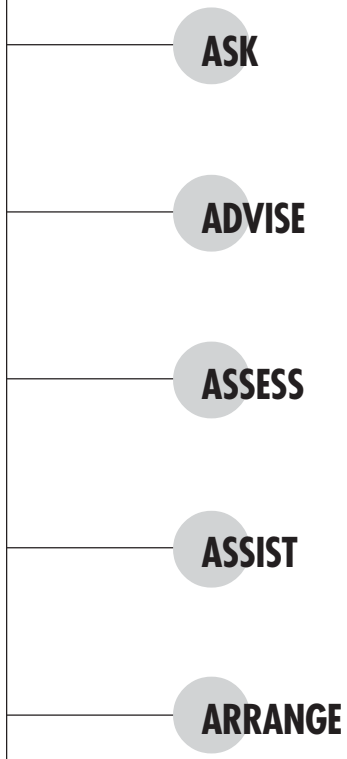
Smoking Cessation During Pregnancy: Guidelines for Intervention

November 2002



Smoking Cessation During Pregnancy: Guidelines for Intervention

November 2002

Maternal and Child Health
P.O. Box 47880
Olympia, WA 98504-7880
Phone: 360-236-3505
Website: http://www.doh.wa.gov

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Edited by

Diane Bailey, MN
Polly Taylor, CNM, MPH, ARNP
Jeanette Zaichkin, RNC, MN

Contributors and Reviewers

Diane Barker, PhD
Thomas Benedetti, MD
Laurie Cawthon, MD, MPH
Sallie Dacey, MD
Freida Eng, MD
Sue Green, MPA
Joan Helmich
Sue Kearns, RNC, MN
Karen Krueger, MN
Cathy Melvin, PhD, MPH
Gail Peterson, MN
Roger Rowles, MD
Diane Tiffany, MSN
Tamatha Thomas-Hasse

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- American College of Obstetrics and Gynecology. *Educational Bulletin No. 260*, September 2000.
- Arizona Department of Health, Tobacco Education Program. *Basic Tobacco Intervention Skills Certification Guidebook*, 2001.
- US DHHS, Public Health Service. *Clinical Practice Guideline: Treating Tobacco Use and Dependence*, June 2000.
- Smoke-Free Families. *Need Help Putting Out That Cigarette?*, 2002.
- Smoke-Free Families and American Cancer Society. *A Quit Line Protocol for Pregnant Smokers*, 2001.

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Introduction

Reducing tobacco use among pregnant and parenting women is a top public health priority in Washington State. Smoking accounts for 20 to 30 percent of all low birth weight babies born nationwide, and many consider smoking to be the single most important preventable cause of low birth weight.

Besides low birth weight, smoking during pregnancy is associated with maternal and infant morbidity and mortality. Additional risks associated with tobacco use during pregnancy include SIDS, preterm birth, ectopic pregnancy, miscarriage, placenta previa and abruption, intrauterine growth restriction and other complications.[1]

In our state, the rates of smoking are especially high for low-income pregnant women receiving Medicaid. In 2001, the rate of smoking during pregnancy was 18.7 percent for women on Medicaid compared to 4.9 percent for non-Medicaid women.[2] Of women on Medicaid giving birth in 2000, the singleton low birth weight rate for smokers was 7.6 percent compared to 4.5 percent for non-smokers.[3]

Because of these disparities, the state Department of Health Tobacco Prevention and Control Program, Maternal and Child Health Program and the Depart-

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1 American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." ACOG Educational Bulletin 260. Washington, DC: ACOG, 2000.

2 Cawthon, L. "Characteristics of Women Who Gave Birth in Washington State." Washington State Department of Social and Health Services, First Steps Database, April 8, 2002.

3 Cawthon, L. Unpublished, 2002.

ment of Social and Health Services Medical Assistance Program (Medicaid) are partnering to address tobacco use by low-income pregnant and parenting women. Effective January 1, 2002, Medical Assistance Administration (MAA) in the Department of Social and Health Services (DSHS) added coverage of a smoking cessation benefit for pregnant and postpartum women on Medicaid (up to two months postpartum). (See Appendix A) By July 1, 2003, all First Steps maternity support services providers will have received skills training in how to work with mothers to stop/ reduce cigarette use during pregnancy and environmental tobacco smoke exposure to their infants.

According to the US Public Health Service, an office-based protocol that systematically identifies pregnant smokers and provides an intervention has been proven to increase quit rates. Current literature suggests that programs designed specifically for pregnant women begun early in pregnancy are the most effective. A brief intervention of 5-15 minutes by a trained provider plus appropriate referrals and resource materials will result in an expected cessation rate of 15-20% for ***light to moderate smokers***. This has been demonstrated in all racial and ethnic groups.[4] ***Heavy smokers*** can also benefit from a client centered, non-threatening intervention. The goal of the intervention is to understand the woman's position regarding smoking during pregnancy,

[4] Melvin C, Dolan-Mullen P, Windsor R, Whiteside HP, and Goldberg, RL. "Recommended Cessation Counseling for Pregnant Women Who Smoke: A Review of the Evidence." *Tobacco Control*, Suppl III, Vol 9, iii 80-84, 2000.
Rollnick S, Mason P, and Butler C. *Health Behavior Change: A Guide for Practitioners*. Churchill Livingstone, 1999.

the importance she places on quitting and her confidence in being able to succeed. For those pregnant women who are ready to quit, the provider can offer help. For those pregnant women who feel cessation is not a priority, a trained provider can share information about why smoking cessation promotes healthier outcomes for the pregnant woman and her baby.

The purpose of this booklet is to provide clinicians with information about how to conduct this type of brief intervention with pregnant women, offer resources for pregnant women who want to quit, and provide information about use and prescription of smoking cessation pharmaceutical aids during pregnancy. We have included information on Nicotine Replacement Therapy (NRT), both over-the-counter and prescription NRT, and Bupropion SR.

It is hoped that this information will help all health care professionals who work with pregnant women to enhance their skills related to smoking cessation interventions, and ultimately reduce tobacco use during and after pregnancy.

Brief Intervention Tool[5]

The brief (5–15 minutes) intervention is most effective with pregnant women who ***smoke less than 20 cigarettes per day***.[6] This is the recommended starting point for identifying all pregnant women who smoke and assisting those who are ready to stop.

ASK

Ask the patient to choose the statement that best describes her smoking status:

A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.

B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.

C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.

D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.

E. I smoke regularly now, about the same as BEFORE I found out I was pregnant.

If the patient has never smoked or has smoked very little (A), acknowledge this wise choice and assess the need to ask about second had smoke exposure. If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, con-

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[5] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." ACOG Educational Bulletin 260. Washington, DC: ACOG, 2000.

[6] Melvin C, Dolan-Mullen P, Windsor R, Whiteside HP, and Goldberg, RL. "Recommended Cessation Counseling for Pregnant Women Who Smoke: A Review of the Evidence." *Tobacco Control*, Suppl III, Vol 9, iii 80-84, 2000.

gratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and beyond postpartum.

If the patient is still smoking (D or E), document smoking status in the medical chart, and proceed to Advise, Assess, Assist, and Arrange.

ADVISE

Ask the client to tell you what she knows about smoking during pregnancy, then ask permission to share the health message. This seemingly small change in approach gives the health care provider an opportunity to hear the client's position on smoking, including potential barriers to quitting. With this approach, the client may be less resistant to the message of quitting. Provide clear advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus.

"Quitting smoking lessens your risk for miscarriage, preterm delivery and stillbirth. Your baby starts getting more oxygen after just one day of not smoking."

ASSESS

Before assessing the woman's readiness to quit, consider asking the woman what she thinks of the health message you shared with her about smoking during pregnancy. Does she have any questions? Then assess the willingness of the patient to attempt to quit within 30 days.

"Quitting smoking is one of the most important things you can do for your health and for your baby's health. If we can give you some help, are you willing to try?"

If the patient is ready to quit, proceed to Assist.

If the patient is not ready, provide information to motivate the patient to quit and proceed to Arrange.

ASSIST

Briefly explore problem-solving methods and skills for smoking cessation.

- Identify "trigger" situations

Provide social support as part of the treatment.

- "Is there something we could do to help you?"

Discuss social support in her environment.

- Identify her "quit buddy" and her smoke-free space

Provide pregnancy-specific, self-help smoking cessation materials.

Set a quit day and assist in developing a quit plan, and document in the medical chart. Refer the client to the Tobacco Quit Line (1-877-270-7867), if appropriate.

ARRANGE

Before the woman leaves, let her know that you will be checking in to see how she is doing at each visit. Ask her to call if she has questions or concerns.

Assess smoking status at subsequent prenatal visits and, if the patient continues to smoke, encourage cessation.

Affirm all efforts to change and continue to assist her with her efforts to quit. Document status and assistance in the medical chart.

Stages of Change and Motivational Interviewing

The Stages of Change

The Stages of Change model developed by Prochaska and DiClemente (1982) is one approach to understanding the steps to changing tobacco use during pregnancy. The stages of change are:

- Pre-contemplation (not ready to quit)
- Contemplation (thinking about quitting)
- Preparation (ready to quit)
- Action (quitting)
- Maintenance (staying quit)
- Relapse (using again)

Precontemplation. The woman is not considering change during the pre-contemplation stage.

- She may not believe it necessary (for example: she smoked during her last pregnancy and nothing happened, or her mother smoked while pregnant with her and she is okay).
- She may not know or understand the risks involved.
- She has tried many times to quit without success, so she has given up and doesn't want to try again.
- She has gone through withdrawal before and is fearful of the process or its effects on her body.
- She feels strongly that no one is going to tell her what to do with her body.
- She has family members or a partner, whom she depends on, who smoke. She may not contemplate changing when everyone else in her environment continues to smoke.

The woman in pre-contemplation may be resistant, reluctant, or resigned.

Resistant: "Don't tell me what to do."
Provider response: Work with the resistance. Avoid confrontation by giving facts about what smoking does to her and her fetus. Ask what she knows about the effects of tobacco. Ask permission to share what you know, then ask her opinion of the information. This often leads to a reduced level of resistance and allows for a more open dialogue.

Reluctant: "I don't want to change. There are reasons. How will I cope?"
Provider response: Empathize with her perceived barriers to change. It is possible to give strong advice and still be empathetic to possible hardships that come with changing. Guide her problem solving. (See page 19)

Resigned: "I can't change, I've tried."
Provider response: Instill hope. Explore barriers to change. (See page 19)

These clients may respond to a brief motivational intervention called the "5 Rs". (See Appendix B)

Contemplation. The woman is ambivalent about changing her behavior. She can think of the positive reasons to change but also is very aware of the negative sides of change.

Ambivalent: "I know I should quit. I feel guilty every time I have to light up."
Provider response: Health care providers can share information on the health benefits of smoking cessation for the woman and her fetus. The woman in contemplation will hear these benefits, but is very aware of the negative aspects of change on her life. Help the woman explore goals for a healthy pregnancy, and how to deal with the negative aspects of abstinence. (See pages 20-24) Reinforce that she *can* quit smoking.

Preparation. The woman's ambivalence is shifting toward changing her behavior. She is exploring options to assist her process. She may be experimenting by cutting down, or has been able to quit for one or more days. Although her ambivalence is lessening, it is still present and may increase when she is challenged by those around her, or triggered by stress or the environment.

Preparing: "Sometimes I can skip my lunch break cigarette and I feel good about that, but I can't seem to skip the afternoon cigarette break. All my friends are smoking out there without me."
Provider response: Acknowledge her strengths. Anticipate problems and pitfalls to changing, and assist the woman in generating her own quit plan. Problem solve her barriers to success. (See page 19)

Action. The woman has stopped smoking.

Abstainer: "It's tough, but I know this is important for my baby's health. I'm glad I quit."
Provider response: Acknowledge her success and how she is helping her infant and herself. Ask her to share how she has succeeded and how she is coping with the challenges of not smoking. Offer to be available for assistance is she feels that she wants to smoke again. Provide relapse prevention materials.

Maintenance. The woman stopped smoking before she became pregnant or early in her pregnancy and has

maintained abstinence for several months. However, she may consider this cessation as only an interruption in her smoking behavior.

Maintainer: "I'll stop while I'm pregnant" or "If I can stop now, I can stop whenever I want."
Provider response: Check in with the woman on a regular basis. Affirm her success at cessation and assess how she is handling triggers and stress. Pregnancy offers a unique incentive to quit and once she is not pregnant, she may easily smoke again. Encourage her to stay quit for her own health and the health of her child. Taking time to explore this with the client before she delivers may help reduce her chance of relapse.

Relapse. The woman returns to smoking. Incidence of relapse for heavy smokers and for postpartum women who are able to quit during pregnancy is high. After the baby is born, the majority of women return to smoking.

Relapser: "I tried, but I couldn't maintain. At least I quit while I was pregnant."
Provider response: For women who have quit during pregnancy, anticipatory guidance may be helpful in preventing relapse after delivery. Identify strategies for dealing with triggers and stressors that may present after delivery. If relapse is evident at future visits, help the woman identify what steps she used in previous attempts to quit. Offer hope and encouragement, but allow the woman to explore the negative side of quitting and what she can do to deal with those issues. How did she deal with those issues in the past? Explore what worked and didn't work for her. Offer resources to help her return to abstinence. (See page 25)

Provider Scripts for Motivating the Client

Cutting Down

If she says no to quitting, but has cut down or wants to cut down: Smoking is a complex addictive behavior. For heavy smokers who continue to smoke during pregnancy, harm reduction strategies are something to consider.

Provider prompt: "I want to help you do what you want to do, and I understand that you'd like to cut down on your smoking. That's great. Quitting smoking completely is the best thing you can do for your baby, but smoking fewer cigarettes is better than smoking more cigarettes. So, can you think about how many cigarettes you would like to cut down to?"

Provider response: Acknowledge her response and praise her plans to change. Ask if she wants to start cutting back right away. If she wants to start, brainstorm things she can do to occupy her hands (doodle, crafts, rubber band), mouth (gum, straw, hard candy), and mind (distract herself, think of baby). Arrange to call her in a week to see how she's doing. Remind her to use the written materials she has received (or will receive). Continue to assess her readiness to quit.

Preparing to Quit

The first step of your support plan is to work with her to develop an individualized quit plan.

Provider prompt: "How are you feeling about your smoking situation?" How many cigarettes a day are you smoking now?"

Provider response: Acknowledge her feelings. Give heavy reinforcement for desire to quit. Remind her to use her self-help materials. Write down the number of cigarettes she smokes per day and praise her if she has cut down.

If She Has Set a Quit Day

This is a big step and demonstrates her readiness to change her behavior. Encourage her to talk about her concerns, determine the degree of support in her environment, help her identify high risk smoking situations, review her reasons for quitting and review how she can prepare for the quit day.

Provider prompt for talking about her concerns: "How do you feel about your plans to quit smoking? Do you have any questions or concerns?"

Provider response: Problem-solve with her about perceived problems. Use information in the self-help materials. Remind her that you are available to help and support her as she prepares for this quit attempt. Remind her that quitting smoking is the most important thing she can do for herself and her baby.

Provider prompt for assessing support: "How do you think the people around you feel about your plans to quit (cut down)? Are you around other smokers?"

Provider response: Acknowledge advantages of having support from others and not having smokers around her OR problem-solve using the information on pages 19 and 20.

Provider prompt for identifying high risk situations: "What particular times of the day do you think might be hardest to get through without smoking?"

Provider response: Problem-solve around one high-risk time or situation.

Provider prompt for reviewing reasons to quit: "Last time we talked you mentioned some pretty important personal reasons for quitting (cutting down) (list them for her). Some women like to write those down, stick them on the refrigerator and look at them when they need to remind themselves why they're doing this. Some women also like to talk to their baby about the reasons. They tell their baby, 'Hey, this is what I'm doing for you.'"

Provider response: Give strong reinforcement for her personal reasons to quit. Encourage her to think of more ways to remind herself of this worthy goal.

Preparing a Quit Day Plan

Eighty percent of successful ex-smokers quit "cold turkey" by setting a Quit Day and stopping completely on that day. If a woman is not ready to set a Quit Day, suggest that she cut down the number of cigarettes she smokes in preparation for quitting. If the woman has set a Quit Day, suggest the following as ways to prepare:

- Get rid of smoking materials before quitting (totally shred cigarettes to remove temptation; clean out ashtrays; give away lighters, matches; make it hard to access a cigarette)

- Be clear on reasons for quitting (state them and rehearse them regularly)
- Be ready for urges to smoke. Plan some specific things to do when urges occur (see page 22); and find ways to occupy hands, mouth, and mind
- Ask for help and encouragement from others, preferably ex-smokers who know what you're going through

Quit Day Follow-up Call

Consider having someone make a quit day follow up call. Ask the woman if this would be okay and helpful to her. Make additional support calls between prenatal care visits if this is a possibility in your setting, and agreeable to the client.

Provider prompt: "Today is your quit day. Are things going as planned?"

Provider prompt: "What kinds of difficulties are you having today?

Provider prompt: "How are you doing with negative feelings, like stress, without smoking?"
"Are you having difficulty dealing with others smoking around you?"
"Are you having strong urges or cravings for a cigarette?"
"Have you noticed any strong withdrawal symptoms?"

If she has not quit smoking, but seems to be doing well cutting down, ask if she would be willing to set another quit date.

Provider prompt: "How many cigarettes a day are you smoking now?"
Provider response: Document her response and praise any decrease in smoking.

Provider prompt: "You seem to be doing very well cutting down on your smoking, and smoking fewer cigarettes is better than smoking more cigarettes. As you know, it's best to quit completely. I'm wondering if you'd be willing to set another quit date at this point."
Provider response: If yes, praise her, write down her quit date, and help her prepare to quit.

Praise all women who are attempting to quit and encourage self-care during this stressful process.

Provider prompt: "I know that it's not an easy process to quit smoking (to cut down on the number of cigarettes you smoke), but I think it's great that you're working on it. Can you think of ways you can pamper yourself while you're changing your smoking habit?"
Provider response: Suggest things other women have done to pamper themselves such as shopping, a back rub, telephoning someone she has not talked to in a long time, taking a bubble bath, buying a plant or flowers, going for a relaxing walk, going out for ice cream.

Anticipating and Managing Problems

The problem-solving process is a way to help a woman figure out how to handle situations or feelings that set the stage for smoking. The goal of problem solving is to come up with one or more practical ways to handle a high-risk situation without smoking. Steps to problem solving are listed below.

1. Clearly define the problem. Ask the woman to identify as specifically as possible the situation or feeling that created an urge to smoke. Get a clear, concrete, circumscribed definition of the problem such as

- I was at a friend's house, and she lit up a cigarette.
- I had an argument with my husband, and was feeling angry with him.
- The kids were driving me crazy, and I needed a break.

2. Develop possible solutions. Ask the woman to think of several different things she could do to handle the situation or feeling without smoking. Do not evaluate the solutions at this point, simply ask her to come up with as many possibilities as she can. Acknowledge all of her suggestions no matter how unrealistic they may be.

3. Add to her list of possible solutions. Suggest a few of your own solutions. Do not evaluate any solutions yet.

4. Choose one or two solutions from the list to try. Go over the list of solutions with the woman and ask her which could really be used in the situation described. Be sure that the solution or solutions chosen are practical for her. If none are realistic, repeat Steps 2, 3, and 4.

5. Get agreement to try out the solution. Ask her if she would be willing to try out the solution the next time

she is faced with the problem situation or feeling. Tell her you'd like to hear how it worked the next time you talk with her.

Problem #1: Being Around Smokers

Thirty percent of relapses occur when an ex-smoker is around someone smoking. This is a high-risk situation because of the visual and olfactory cues to smoke, and cigarettes are readily available.

Management strategies for the client:

- Try to avoid the situation in the first place.
- Ask friends or family members to quit with you.
- Ask others not to smoke around you, now that you're pregnant.
- Recite reasons for quitting.
- Leave the room when others light a cigarette.
- Plan ways to distract yourself when someone else is smoking (least preferred option because you are still in the presence of the cigarette). Find ways to occupy your hands (knit or sew, play with a straw or rubber band, hold a pen or pencil, draw or doodle, squeeze a rubber ball, work on a craft project), your mouth (suck on hard candy, chew gum, use a toothpick or straw, sip water or juice, try a cinnamon stick, eat some fresh fruit), and your mind (think about the baby or a pleasant activity not involving smoking).

Problem #2: Coping with Negative Feelings

Over 50% of relapses occur when an ex-smoker is feeling some sort of negative emotion. It can be a "high energy" negative emotion such as anger, stress, anxiety, or frustration, or it can be a "low energy" negative emotion such as loneliness, boredom, or sadness. Many women perceive that a cigarette helps them cope with the negative emotion. Smoking does not take the negative feeling away completely, but it tempers it slightly, making it less intense. When you stop smoking, you lose that coping strategy, leaving the full force of the negative feelings. The goal is to find ways other than smoking (and drinking) to reduce the negative emotions.

Management strategies for the client:

- Take a hard candy break (if clinically appropriate). Sucrose (sugar) seems to have some soothing properties and is a good substitute for having a cigarette when experiencing a negative emotion. Like a cigarette, it is immediate, inexpensive, and portable, and it lasts for several minutes. Hard candies (such as sour balls, lemon drops, life savers, lollipops) that are purely sugar and no fat don't add many calories, but can help to temper a negative emotion.
- Do something physical. Burn up some of the negative energy through physical activity. Take a walk, sweep or vacuum the floor, do some gardening, turn on music and dance.
- Express feelings. The idea is to modulate some of the negative emotions by expressing them. Write down those feelings, say them into a tape recorder, talk with a friend.
- Relax. Gradually bring down the level of negative energy. Take a hot bath or shower, listen to your favorite soothing music, take ten slow, deep breaths, think about a favorite peaceful place, meditate, stroke a pet.

- Redirect thoughts. See if you can change your mood by thinking of something that made you feel good, something you accomplished or mastered, or something you enjoyed in the past.
- Build your own support system. Ask others to be aware that this is a difficult time. Prepare them for your irritability and moods, and ask for help in doing some of your routine tasks.

Problem #3: Coping with Urges

Most people get urges for a cigarette after quitting. Urges often occur when doing something associated with smoking. What situations set the stage for having an urge? Examples include talking on the phone, riding in the car, finishing a meal, drinking coffee, taking a break, or talking with friends.

Management strategies for the client:
- Change your routine when possible. Hold the phone receiver in the other hand, play with a straw when riding in the car, get up from table after a meal, doodle, play with a rubber band, or knit when taking a break, or eat hard candy when talking with friends.
- Distract yourself. Occupy your hands (knit or sew, play with a straw or rubber band, hold a pen or pencil, draw or doodle, squeeze a rubber ball, work on a craft project), your mouth (suck on hard candy, chew gum, use a toothpick or straw, sip water or juice, try a cinnamon stick, eat some fresh fruit), and your mind (think about the baby or a pleasant activity not involving smoking).
- Think your way out of the urge. Remind yourself why you decided to quit smoking. Tell yourself how well you've done so far not smoking, think about how proud you'll feel getting through the day without a cigarette, figure out how much money you're saving by not smoking.
- Change your environment. Remove things that might remind you to smoke, go somewhere else in the house or outside when you get the urge to smoke.

Problem #4: Managing Withdrawal Symptoms

Some people have withdrawal symptoms for several weeks after quitting. Withdrawal symptoms are normal, although they may be uncomfortable. It's helpful to remember that they don't last long, and they are positive signs that your body is recovering from smoking.

Management strategies for the client:
- Irritability. Prepare people around you to expect that you may be irritable for several weeks. Decrease demands on yourself, drink lots of water or fruit juices to get the nicotine out of your system, avoid stimulants like caffeine in coffee and cola, take 10 slow, deep breaths to calm yourself down, do some physical activities.
- Cough and sore throat. Don't worry if your cough gets worse shortly after quitting. This is a good sign that your lungs are clearing. Take cough drops for temporary relief.
- Dizziness and headache. Your body is getting used to living without nicotine. Take a walk and breathe fresh air, sit down if you feel dizzy. Take a nap.
- Hunger. You may have an increased appetite; eat healthy low-fat snacks that are high in texture and crunch such as plain popcorn, pretzels, celery, carrots,

and fruit. Suck on hard candy. Drink lots of water.
- Difficulty concentrating. Do something physical to burn off nervous energy (take a walk, clean the house, garden, dance). Reduce work demands during this period if possible. Work in short bursts rather than for extended periods, and get lots of sleep.
- Constipation. Increase the amount of fruit, vegetables, and bran in your diet, and drink lots of water.
- Restlessness. Do something physical (take a walk, clean the house, garden, or dance). Keep your hands busy (doodle, knit, play with a straw, rubber band, worry beads, a craft). Avoid caffeine.
- Sleeplessness. Avoid caffeine at night. Exercise more during the day. Go to bed only when tired. When you can't sleep at night, get out of bed and do something such as reading or working on a hobby until drowsy.

Problem #5: Coping with Weight Gain

The average person gains no more than 10 pounds after quitting; however, weight gain during pregnancy is normal. If you are worried about gaining weight when you quit smoking, now is an ideal time to quit.

Management strategies for the client:
- Recognize that weight gain is normal. Weight gain is far less harmful than the consequences of smoking. You're supposed to gain weight during pregnancy anyway, so this is a great time to quit smoking. Accept the weight gain and deal with it after you have your smoking under control after delivery.
- Increase your physical activity. This burns calories to help offset the decrease in metabolic rate associated with quitting smoking. You can do this by making some changes in your lifestyle. Walk instead of ride whenever possible. Take stairs instead of the elevator. Do something physical for recreation.
- Make some changes in your diet. Avoid foods high in fat (ice cream, cheese, whole milk, cream) and products made with butter, Crisco, coconut, palm, or hydrogenated oils. Avoid high fat snack foods such as chips, nuts, and chocolate. Substitute low-fat dairy product alternatives (skim milk, sherbet or ice milk, light cheeses). If you crave something sweet, eat something containing sugar but low in fat (hard candy, sherbet, fruit pops, graham crackers). For snacks, consider hard candy, ice chips, fruit pops, lowfat yogurt, sherbet, plain popcorn, or pretzels.

Problem #6: Coping with "Slips"

Almost everyone slips up at some point during the quitting process. The trick is to learn from the slip and begin again.

Management strategies for the client:
- Do not tempt yourself by smoking even one drag off one cigarette; however, people sometimes slip and smoke a cigarette after quitting.
- Tell yourself that this relapse was a mistake, not a failure.
- Review your reasons for quitting. Blame the situation, not yourself. Renew your commitment to staying quit.
- Problem-solve how to avoid getting into that situation in the future.
- Review your commitment to quitting.
- Ask for help from others who want to see you succeed.

Provider Script for Managing Relapse

Acknowledge her smoking status and her feelings.
Provider prompt: "Okay, I understand that you're smoking. How are you feeling?"

Ask her to describe the situation in which she relapsed.
Provider prompt: "Can you tell me what was going on when you had that first cigarette?" (Get a clear description of the situation or feeling.)

Use the problem-solving process to generate possible ways she could have handled that situation or feeling.
Provider prompt: "What are some other ways you could have handled that situation without smoking?" (Don't evaluate yet; add some suggestions from the problem solving section, page 19.)

Reassure her that people often quit a number of times before they're successful.
Provider prompt: "It's important for you to know that people often quit a number of times before they're successful."

Ask if she'd be willing to set a new Quit Day.
Provider prompt: "Would you be willing to set a new Quit Day? I'd be happy to help you."

Provider response if Yes: "That's great. What day would you like to set as your Quit Day? Do you have a sense of how you'll prepare for quitting?" (Review her plans, ask permission to give her materials and make arrangements to call her on her new Quit Day.)

Provider response if No: "Okay, I realize that you're not ready to quit again right now. Would it be okay if I

talked with you in a few weeks to see how you feel about it then?" (If yes, then make arrangements to do this and ask about sending materials. If no, check in again at your next encounter.)

Pharmacotherapy

The Department of Health does not recommend that all pregnant women who smoke use pharmaceutical cessation aids. However, heavy smokers who do not respond to a behavioral intervention may benefit from pharmacotherapy.[7] Prescribing any medication or encouraging the use of non-prescription medicines during pregnancy is a matter of individual clinical judgment. Risks and benefits must be evaluated and shared with the pregnant woman. The ACOG Smoking Cessation During Pregnancy Education Bulletin of September 2000 makes the following statement:

> The use of nicotine replacement products or other pharmaceuticals as smoking cessation aids during pregnancy has not been sufficiently evaluated to determine its efficacy or safety. Nicotine gum and patches should be considered for use during pregnancy only when nonpharmacologic treatments (counseling) have failed, and if the increased likelihood of smoking cessation, with its potential benefits, outweighs the unknown risk of nicotine replacement and potential concomitant smoking. Research to determine the safety and efficacy of pharmacotherapy is strongly recommended because potential benefits seem to outweigh potential risks.[8]

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[7] Windsor R, Oncken C, Henningfield J, Hartman K, and Edwards N. "Behavioral and Pharmacological Treatment Methods for Pregnant Smokers: Issues for Clinical Practice." *Journal of the American Medical Women's Association*, 55(5), 304-310, Fall 2000.

[8] American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." ACOG Educational Bulletin 260. Washington, DC: ACOG, 2000.

The Public Health Service Clinical Practice Guideline, "Treating Tobacco Use and Dependency," makes the following statement related to use of NRT during pregnancy:

> If the clinician and pregnant or lactating patient decide to use NRT pharmacotherapy, the clinician should consider monitoring blood nicotine levels to assess the level of drug delivery. In addition, the clinician should consider using medication doses that are at the low end of the effective dosage range, and consider choosing delivery systems that yield intermittent, rather than continuous drug exposure (e.g. nicotine gum rather than nicotine patch). Because none of these medications has been tested in pregnant women for efficacy in treating tobacco dependence, the relative ratio of risks to benefits is unclear. Additionally, since small amounts of these medications are passed through breast milk, they may pose some risks for nursing infants.[9]

There are no guidelines at present for combining the nicotine patch with a self-administered form of NRT. Further, there is not yet sufficient data to determine whether combination NRTs are particularly efficacious with subpopulations of smokers.[10]

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[9] US DHHS Public Health Service. *Clinical Practice Guideline: Treating Tobacco Use and Dependence*, 31-33, June 2000.

[10] Ibid.

Material in the pharmacotherapy section adapted from:

US DHHS Public Health Service. *Clinical Practice Guideline: Treating Tobacco Use and Dependence*, June 2000.

Hale, T. *Medications and Mothers' Milk*, 9th ed. Amarillo,Texas: Pharmasoft Publishing, 2000.

Arizona Department of Health, Tobacco Education Program. *Basic Tobacco Intervention Skills Certification Guidebook*, 2001.

Clinical Use for Bupropion SR/Zyban (FDA approved)

Patient selection

Appropriate as a first-line pharmacotherapy for smoking cessation.

Description

Non-nicotine medication for use in quitting smoking. Zyban reduces withdrawal symptoms, especially cravings and weight gain, for many patients. In clinical trials, Zyban was more effective than nicotine replacement. Zyban can be used with nicotine replacement.

Precautions

Under 18 years

Pregnancy—Pregnant smokers should be encouraged to quit first without pharmacologic treatment. Bupropion SR should be used during pregnancy only if the increased likelihood of smoking abstinence, with its potential benefits, outweighs the risk of bupropion SR treatment and potential concomitant smoking. Similar factors should be considered in lactating women. (FDA Class B: Either animal-reproduction studies have not demonstrated a fetal risk but there are no controlled studies in pregnant women, or animal-reproduction studies have shown an adverse effect that was not confirmed in controlled studies in women in first trimester and there is no evidence of risk in later trimesters.)[11]

Lactating mothers—Bupropion and its metabolites are secreted in human milk. Lactation Risk category L3 (moderately safe). The peak milk bupropion level occurred two hours after a 100mg dose. This milk level would provide 0.019% of the maternal dose, a dose that is likely to be clinically insignificant to a breastfed infant.[12]

Cardiovascular diseases—Generally well tolerated; infrequent reports of hypertension.

Side effects—The most common side effects reported by bupropion SR users were insomnia (35-40%) and dry mouth (10%).

Contraindications—Bupropion SR is contraindicated in individuals with a history of seizure disorder, a history of an eating disorder, who are using another form of bupropion (Wellbutrin or Wellbutrin SR), or who have used an MAO inhibitor in the past 14 days. Bupropion lowers the seizure threshold and may increase seizure risk in women with preeclampsia.

Dosage

Patients should begin with a dose of 150 mg. q AM for 3 days, then increase to 150 mg b.i.d. Dosing at 150 mg b.i.d. should continue for 7-12 weeks following the quit date. Unlike nicotine replacement products, patients should begin bupropion SR treatment 1-2 weeks before they quit smoking. For maintenance therapy, consider bupropion SR 150 mg b.i.d. for up to 6 months.

Availability

Zyban—Prescription only.

Prescribing instructions

Scheduling of doses—If insomnia is marked, taking the PM dose earlier (in the afternoon, at least 8 hours after the first dose) may provide some relief.

Alcohol—Reinforce that alcohol should be avoided during pregnancy, lactation and while on this drug.

Side effects—Insomnia, dry mouth, nervousness, difficulty concentrating, rash or constipation. Side effects are usually observed at start of therapy.

Cost/day*

$3.33

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[11] Hale, T. *Medications and Mothers' Milk*, 9th ed. Amarillo,Texas: Pharmasoft Publishing, 2000.

[12] Ibid.

* Cost data is based on the retail price of the medication purchased at a national chain pharmacy located in Madison, WI April 2000.

Clinical Use for Nicotine Nasal Spray (FDA approved)

Description

Contains nicotine in a solution. It is designed to be used in the same fashion as other nasal sprays.

Precautions

Under 18 years

Smokes fewer than 10 cigarettes per day

Pregnancy—Pregnant smokers should be encouraged to quit first without pharmacologic treatment. Nicotine nasal spray should be used during pregnancy only if the increased likelihood of smoking abstinence, with its potential benefits, outweighs the risk of nicotine replacement and potential concomitant smoking. Similar factors should be considered in lactating women. (FDA Class D: There is positive evidence of human fetal risk, but the benefits from use in pregnant women may be acceptable despite the risk, e.g. if drug is needed in a life-threatening situation or for a serious disease.)

Cardiovascular diseases—Nicotine replacement therapy (NRT) is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) post myocardial infarction period, those with serious arrhythmias, and those with serious or worsening angina pectoris.

Nasal/airway reactions or sinus allergies—Some 94% of users report moderate to severe nasal irritation in the first 2 days of use; 81% still reported nasal irritation after 3 weeks, although rated severity was mild to moderate. Nasal congestion and transient changes in sense of smell and taste also were reported. Nicotine nasal spray should not be used in persons with severe reactive airway disease.

Dependency—Nicotine nasal spray has a dependence potential intermediate between other nicotine-based therapies and cigarettes. About 15-20% of patients report using the active spray for longer periods than recommended (6-12 months), and 5% used the spray at a higher dose than recommended.

Dosage

A dose of nicotine nasal spray consists of on 0.5 mg delivery to each nostril (1 mg. total). Initial dosing should be 1-2 doses per hour, increasing as needed for symptom relief. Minimum recommended treatment is 8 doses/day, with a maximum limit of 40 doses/day (5 doses/hr). Each bottle contains approximately 100 doses. Gradually decrease use over 6-8 weeks. Recommended duration of therapy is 3-6 months.

Availability

Nicotrol NS—Prescription only.

Prescribing instructions

Dose delivery—Patients should not sniff, swallow, or inhale through the nose while administering doses as this increases irritating effects. The spray is best delivered with the head tilted slightly back. Many users complain of a hot peppery sensation in the nose or throat.

Side effects—Persistent sneezing, coughing or runny nose and watery eyes, irregular heartbeat or palpitation. Nicotine overdose: nausea, vomiting, dizziness, weakness, rapid heartbeat.

Cost/day*

$5.40 for 12 doses; $36.00 for 10 ml Nicotrol NS (about one week supply)

* Cost data is based on the retail price of the medication purchased at a national chain pharmacy located in Madison, WI April 2000.

Clinical Use for the Nicotine Inhaler (FDA approved)

Patient selection

Appropriate as a first-line pharmacotherapy for smoking cessation. Kit includes a plastic, reusable mouthpiece with nicotine impregnated plugs that are inserted into the mouthpiece for use. All nicotine is delivered through the lining of the mouth rather than the lungs.

Precautions

Under 18 years

Smokes fewer than 10 cigarettes a day

Takes prescription medicine for depression or asthma—Prescription may need to be adjusted.

Pregnancy—Pregnant smokers should be encouraged to quit first without pharmacologic treatment. The nicotine inhaler should be used during pregnancy only if the increased likelihood of smoking abstinence, with its potential benefits, outweighs the risk of nicotine replacement and potential concomitant smoking. Similar factors should be considered in lactating women. (FDA Class D: There is positive evidence of human fetal risk, but the benefits from use in pregnant women may be acceptable despite the risk, e.g. if drug is needed in a life-threatening situation or for a serious disease.)

Cardiovascular diseases—NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) post myocardial infarction period, those with serious arrhythmias, and those with serious or worsening angina pectoris, hypertension not controlled with medication.

Local irritation reactions—Local irritation in the mouth and throat was observed in 40% of patients using the nicotine inhaler. Coughing (32%) and rhinitis (23%) also were common. Severity was

generally rated as mild, and the frequency of such symptoms declined with continued use.

Dosage

A dose of nicotine inhaler consists of a puff or inhalation. Each cartridge delivers 4 mg of nicotine over 80 inhalations. Recommended dosage is at least 6 cartridges/day, but not to exceed 12 cartridges/day. Recommended duration of therapy is up to 6 months. Instruct patient to taper dosage during the final 3 months of treatment.

Availability

Nicotrol Inhaler—Prescription only.

Prescribing instructions

Ambient temperature—Delivery of nicotine from inhaler declines significantly at temperatures below 40°F. In cold weather, the inhaler and cartridges should be kept in an inside pocket or warm area.

Duration—Use is recommended for up to 6 months with gradual reduction in frequency of use over the last 6-12 weeks of treatment.

Absorption—Acidic beverages (e.g., coffee, juices, soft drinks) interfere with the buccal absorption of nicotine, so eating and drinking anything except water should be avoided for 15 minutes before and during inhalation.

Best effects—Best effects are achieved by frequent puffing.

Side effects—Irregular heartbeat, palpitations, symptoms of nicotine overdose such as nausea, vomiting, dizziness, weakness and rapid heartbeat. Report all mouth and jaw problems.

Cost/day*

$10.94 for 10 cartridges. Package with mouthpiece and 48 cartridges is about $50.00.

* Cost data is based on the retail price of the medication purchased at a national chain pharmacy located in Madison, WI April 2000.

Clinical Use for the Nicotine Patch (FDA approved)

Description

Patch with adhesive backing that contains nicotine which is absorbed through the skin.

Precautions

Under 18 years

Smokes fewer than 10 cigarettes per day

Allergic to adhesive tape or have skin problems are more likely to get rashes

Pregnancy—Pregnant smokers should be encouraged to quit first without pharmacologic treatment. The nicotine patch should be used during pregnancy only if the increased likelihood of smoking abstinence, with its potential benefits, outweighs the risk of nicotine replacement and potential concomitant smoking. Similar factors should be considered in lactating women. (FDA Class D: There is positive evidence of human fetal risk, but the benefits from use in pregnant women may be acceptable despite the risk, e.g. if drug is needed in a life-threatening situation or for a serious disease.)

Lactation—A significant amount of nicotine transfers to breast milk. Nicotine levels in milk of patch users are generally less than those found in smokers, assuming the patch is used correctly and the mother abstains from smoking. Patches produce a sustained and lower nicotine plasma level than gum. Those who use patches and smoke would have extremely high levels and would endanger the infant. Patches should be removed at bedtime to reduce exposure to infant and reduce side effects such as nightmares. Nicotine is known to reduce milk production. (Lactation Risk Category L3 moderately safe)[13]

[13] Hale, T. *Medications and Mothers' Milk*, 9th edition. Amarillo, Texas. Pharmasoft Publishing, 2000.

Cardiovascular diseases—NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) post myocardial infarction period, those with serious arrhythmias, and those with serious or worsening angina pectoris; those with hypertension not controlled with medications. Persons taking prescription medicine for asthma or depression; dose may need to be adjusted.
Skin reactions—Up to 50% of patients using the nicotine patch will have a local skin reaction. Skin reactions are usually mild and self-limiting, but may worsen over the course of therapy. Local treatment with hydrocortisone cream (1%) or tramcinolone cream (0.5%) and rotating patch sites may ameliorate such local reactions. In less than 5% of patients, such reactions require the discontinuation of nicotine patch treatment.

Dosage

Treatment of 8 weeks or less has been shown to be as efficacious as longer treatment periods. 16- and 24- hour patches are of comparable efficacy. Clinicians should consider individualizing treatment based on specific patient characteristics such as previous experience with the patch, amount smoked, degree of addiction, etc. Finally, clinicians should consider starting treatment on a lower patch dose in patients smoking 10 or fewer cigarettes per day.

Availability

Nicoderm CQ, Nicotrol, generic—OTC.
Nicotine patches, generic (various doses)—prescription.

Brand	Duration	Dosage
Nicoderm CQ	4 weeks then 2 weeks then 2 weeks	21 mg/24 hours 14 mg/24 hours 7 mg/24 hours
Habitrol		21mg 14mg 7mg
Nicotrol	8 weeks	15 mg/16 hours
ProStep		22mg 11mg

Prescribing instructions

Location—At the start of each day, the patient should place a new patch on a relatively hairless location, typically between the neck and waist.
Activities—No restrictions while using the patch.
Time—Patches should be applied as soon as the patient wakes on their quit day. With patients who experience sleep disruption, have the patient remove the 24-hour patch prior to bedtime or use the 16-hour patch.
Side effects—Irregular heartbeat, palpitations, symptoms of nicotine overdose such as nausea, vomiting, dizziness, weakness and rapid heartbeat. Skin redness. If the redness does not go away after 4 days or rash appears instruct to discontinue.

Cost/day*

Brand name patches (Nicoderm CQ, Nicotrol) $4.00-$4.50; $29.00 to 35.00 per week.
Generic patches recently became available and may be less expensive.

* Cost data is based on the retail price of the medication purchased at a national chain pharmacy located in Madison, WI April 2000.

Clinical Use for Nicotine Gum (FDA approved)

Description

Nicotine is absorbed through the lining of the mouth.

Precautions

Under 18 years of age

Smokes fewer than 10 cigarettes per day

Pregnancy—Pregnant smokers should be encouraged to quit first without pharmacologic treatment. Nicotine gum should be used during pregnancy only if the increased likelihood of smoking abstinence, with its potential benefits, outweighs the risk of nicotine replacement and potential concomitant smoking. Similar factors should be considered in lactating women. (FDA Class D: There is positive evidence of human fetal risk, but the benefits from use in pregnant women may be acceptable despite the risk, e.g. if drug is needed in a life-threatening situation or for a serious disease.)

Lactation—Nicotine gum may produce large variations in peak levels when gum is chewed rapidly, fluctuations similar to smoking itself. Mothers who choose to use nicotine gum and breastfeed should be counseled to refrain from breastfeeding for 2-3 hours after using the gum product. (Lactation Risk Category L3 moderately safe).[14]

Cardiovascular diseases—NRT is not an independent risk factor for acute myocardial events. NRT should be used with caution among particular cardiovascular patient groups: those in the immediate (within 2 weeks) post myocardial infarction period, those with serious arrhythmias, and those with serious or worsening angina pectoris; hypertension not controlled with medication. Person who is taking medication for asthma or depression; dose may need to be adjusted.

Side effects—Common side effects of nicotine chewing gum include mouth soreness, hiccups, dyspepsia, and jaw ache. These effects are generally mild and transient, and often can be alleviated by correcting the patient's chewing technique (see prescribing instructions below). Gum has peppery taste and provides a tingling sensation.

Dosage

Nicotine gum is available in 2 mg and 4 mg (per piece) doses. The 2 mg gum is recommended for patients smoking less than 25 cigarettes per day, while the 4 mg gum is recommended for patients smoking 25 or more cigarettes per day. Generally, the gum should be used for up to 12 weeks with no more than 24 pieces/day. Clinicians should tailor the dosage and duration of therapy to fit the needs of each patient.

Availability

Nicorette, Nicorette Mint—OTC only.

Prescribing instructions

Chewing technique—Gum should be chewed slowly until a "peppery" or "minty" taste emerges, then "parked" between cheek and gum to facilitate nicotine absorption through the oral mucosa. Gum should be slowly and intermittently "chewed and parked" for about 30 minutes or until the taste dissipates.

Absorption—Acidic beverages (e.g., coffee, juices, soft drinks) interfere with the buccal absorption of nicotine, so eating and drinking anything except water should be avoided for 15 minutes before and during chewing.

[14] Hale, T. *Medications and Mothers' Milk*, 9th ed. Amarillo, Texas. Pharmasoft Publishing, 2000.

Scheduling of dose—Patients often do not use enough gum to get the maximum benefit: they chew too few pieces per day and they do not use the gum for a sufficient number of weeks. Instructions to chew the gum on a fixed schedule (at least one piece every 1-2 hours) for at least 1-3 months may be more beneficial than ad libitum use.

Cost/day*

$6.25 for 10, 2 mg pieces; $6.87 for 10, 4 mg pieces. A 48-piece package is about $29.00; a 108-piece package is about $50.00. Gum with 4mg is about one dollar more that 2 mg gum.

* Cost data is based on the retail price of the medication purchased at a national chain pharmacy located in Madison, WI April 2000.

Appendix A: Medicaid Smoking Cessation Counseling Benefit

The brief (5-15 minutes) intervention is most effective with pregnant women who smoke less than 20 cigarettes per day. This is the recommended starting point for identifying all pregnant women who smoke and assisting those who are ready to stop. Washington MAA will cover two levels of smoking cessation counseling: Basic counseling (15 minutes) and Intensive (30 minutes). Up to 10 sessions per client per pregnancy will be covered. Documentation in medical record is required.

DSHS MAA procedure code 99401 (15 minutes) $17.03
DSHS MAA procedure code 99402 (30 minutes) $34.29

ASK

Required for Basic and Intensive Counseling Code

- Ask the patient to choose the statement that best describes her smoking status:
  - A. I have NEVER smoked or have smoked LESS THAN 100 cigarettes in my lifetime.
  - B. I stopped smoking BEFORE I found out I was pregnant, and I am not smoking now.
  - C. I stopped smoking AFTER I found out I was pregnant, and I am not smoking now.
  - D. I smoke some now, but I have cut down on the number of cigarettes I smoke SINCE I found out I was pregnant.
  - E. I smoke regularly now, about the same as BEFORE I found out I was pregnant.
- If the patient stopped smoking before or after she found out she was pregnant (B or C), reinforce her decision to quit, congratulate her on success in quitting, and encourage her to stay smoke free throughout pregnancy and postpartum.
- If the patient is still smoking (D or E), document smoking status, and proceed to Advise, Assess, Assist, and Arrange.

ADVISE

Required for Basic and Intensive Counseling Code

- Provide clear, strong advice to quit with personalized messages about the benefits of quitting and the impact of smoking and quitting on the woman and fetus.
  "Quitting smoking lessens your risk for miscarriage, preterm delivery and stillbirth. Your baby starts getting more oxygen after just one day of not smoking. The sooner you stop the better for your baby."

ASSESS

Required for Basic and Intensive Counseling Code

- Assess the willingness of the patient to attempt to quit within 30 days.
  "Quitting smoking is one of the most important things you can do for your health and for your baby's health. If we can give you some help, are you willing to try?"
- If the patient is ready to quit, proceed to Assist.
- If the patient is not ready, provide information to motivate the patient to quit and proceed to Arrange.

ASSIST

Required for Intensive Counseling Code

- Encourage the use of problem-solving methods and skills for smoking cessation (identify "trigger" situations).
- Provide social support as part of the treatment (e.g., "we can help you quit").
- Arrange social support in the smoker's environment (e.g., identify "quit buddy" and smoke-free space).
- Provide pregnancy-specific, self-help smoking cessation materials.
- Set a quit date and assist in developing a quit plan.

ARRANGE

Required for Intensive Counseling Code

- Assess smoking status at subsequent prenatal visits and, if patient continues to smoke, encourage cessation.
- Praise all efforts to change and continue to assist her with her efforts to quit.

Guidelines for MAA Covered Use of Zyban During Pregnancy

- Establish smoking status.
- Determine that the pregnant woman is ready to quit.
- Develop a Quit plan to include a quit date.
- Provide counseling and other support measures to assist. Refer to QUIT Line: 1-877-270-STOP
- If the nonpharmacotherapy methods have failed to assist and woman is 18 years old or older, consider use of Zyban.
- Track smoking status and progress of quit attempt at each prenatal visit.

MAA covered prescription must include:

1. Client's estimated or actual delivery date
2. Indication that client is participating in smoking cessation counseling.

Material in Appendix A adapted from:

Melvin C, Dolan-Mullen P, Windsor R, Whiteside HP, and Goldberg, RL. "Recommended Cessation Counseling for Pregnant Women Who Smoke: A Review of the Evidence." *Tobacco Control*, Suppl III, Vol 9, iii 80-84, 2000.

American College of Obstetricians and Gynecologists. "Smoking Cessation During Pregnancy." ACOG Educational Bulletin 260. Washington, DC: ACOG, 2000.

Appendix B: The 5 Rs

Enhancing motivation to quit tobacco. This table provides an additional motivational intervention that provides the clinician an opportunity to educate, reassure, and motivate. Motivational interventions are most likely to be successful when the clinician is empathic, promotes patient autonomy, avoids arguments, and helps identify the client's previous successful behavior changes.

Relevance Encourage the patient to indicate why quitting is personally relevant, being as specific as possible. Motivational information has the greatest impact if it is relevant to a patient's disease status or risk, family or social situation (e.g., having children in the home), health concerns, age, gender, and other important characteristics (e.g. prior quitting experience, personal barriers to cessation).

Risks The clinician should ask the patient to identify potential negative consequences of tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. The clinician should emphasize that smoking low-tar/low-nicotine cigarettes or use of other forms of tobacco (e.g., smokeless tobacco, cigars, and pipes) will not eliminate these risks. Examples of risks are:

- *Acute risks*: Shortness of breath, exacerbation of asthma, harm to pregnancy, impotence, infertility, increased serum carbon monoxide.
- *Long-term risks*: Heart attacks and strokes, lung and other cancers (larynx, oral cavity, pharynx, esophagus, pancreas, bladder, cervix), chronic obstructive pulmonary diseases (bronchitis and emphysema), long-term disability and need for extended care
- *Environmental risks*: Increased risk of lung cancer and heart disease in spouses; higher rates of smoking by children of tobacco users; increased risk for low birth weight, SIDS, asthma, middle ear disease, and respiratory infections in children of smokers.

Rewards The clinician should ask the patient to identify potential benefits of stopping tobacco use. The clinician may suggest and highlight those that seem most relevant to the patient. Examples of rewards follow:

- Improved health
- Food will taste better
- Improved sense of smell
- Save money
- Feel better about yourself
- Home, car, clothing, breath will smell better
- Can stop worrying about quitting
- Set a good example for children
- Have healthier babies and children
- Not worry about exposing others to smoke
- Feel better physically
- Perform better in physical activities
- Reduced wrinkling/aging of skin

Roadblocks The clinician should ask the patient to identify barriers or impediments to quitting and not elements of treatment (problem-solving, pharmacotherapy) that could address barriers. Typical barriers might include:

- Withdrawal symptoms
- Fear of failure
- Weight gain
- Lack of support
- Depression
- Enjoyment of tobacco

Repetition The motivational intervention should be repeated every time an unmotivated patient visits the clinic setting. Tobacco users who have failed in previous quit attempts should be told that most people make repeated quit attempts before they are successful.

Material in Appendix B reprinted from:
US DHHS Public Health Service. *Clinical Practice Guideline: Treating Tobacco Use and Dependence*, June 2000.

Appendix C: Tobacco Cessation Resources

DSHS MAA Smoking Cessation Counseling Benefit. MAA will cover two levels of smoking cessation counseling: Basic Counseling (15 minutes) and Intensive (30 minutes). Up to 10 sessions per client per pregnancy will be covered at the following rates in 2002-2003: Basic $17.03 and Intensive $34.29. Documentation in the medical record is required. MAA will also cover Zyban. (See Appendix A)
For more information, check the DSHS website:
http://maa.dshs.wa.gov

Washington Tobacco Quit Line. The Quit Line provides tobacco cessation materials and telephone consultation with Quit Line specialists. Pregnant women can also receive free intensive telephone counseling services with the Free and Clear Program including five calls by Tobacco Specialists over a period of a year.

1-877-270-STOP (1-877-270-7867)

Monday–Thursday	8AM–9PM
Friday	8AM–5PM
Saturday	9AM–1PM

Tobacco Contractors. Your community tobacco contractor sponsors local tobacco cessation activities and has materials. See complete list of Washington State Tobacco Contractors in the Resources section. For the most up-to-date information, check the website:
www.doh.wa.gov/tobacco/contractors/countycoord.htm.

Washington Department of Health Tobacco Clearinghouse. The Clearinghouse has a variety of materials for use with clients, including Quit Line brochures, information on second hand smke, and information on smoking and pregnancy.

Email the Clearinghouse at tobacco.clearing@doh.wa.gov for a complete list of the most recent materials.

Patient Education Resources

How Other Moms Have Quit booklet assists pregnant women to develop and initiate a quit plan. This and other resources are available free from the DOH warehouse. Order forms are available from the DOH website at www.doh.wa.gov or by calling the warehouse 360-586-9046. Orders can be mailed or faxed but are not accepted by phone. A list of additional tobacco cessation materials is available via email at tobacco.clearing@doh.wa.gov

A Pregnant Woman's Guide to Quit Smoking is a 40-page easy-to-follow booklet written at the sixth-grade reading level. The booklet assists pregnant women to develop and implement a quit plan. It has been designed and tested with over 6,000 pregnant smokers and outlines a self-evaluation process to help build smoking cessation success over a 10-day period. This booklet costs between $6.00 and $3.25, depending on number of copies ordered. Contact Society for Public Health Education at 202-408-9804 or info@sophe.org

Organizations

Tobacco Education Clearinghouse of California (TECC) has a catalog of materials for general populations, pregnant and parenting women, and ethnicity/racial specific audiences. There is a charge for these materials. Contact TECC to request a catalog by phone at 831-438-4822 ext.103 or ext.230 or by fax at 831-438-1442.

Websites

Washington State Sites:
The Health of Washington State:
www.doh.wa.gov/hws/default.htm
From the Table of Contents, go to"Major Risk and Protective Factors" for a tobacco link containing a variety of statistics.

Tobacco Prevention and Control: www.doh.wa.gov/Tobacco
Download the 2001 Report "Building a Solid Foundation for a Healthier Washington." Find information on secondhand smoke as well as pregnancy and smoking.

National/International Sites:
Note: Many of these Web sites have search engines specific to their site. In most cases, you can type the keyword "tobacco" in the search box for results relating to tobacco cessation.

American Legacy Foundation: www.americanlegacy.org

Smoke-Free Families: www.smokefreefamilies.org

American College of Obstetricians and Gynecologists:
www.acog.org

Health Care Education and Training, Inc: www.hcet.org

American Lung Association: www.lungusa.org

American Thoracic Society: www.thoracic.org

American Cancer Society: www.cancer.org

American Heart Association: www.americanheart.org

American Medical Association: www.ama-assn.org

U.S. Department of Health and Human Services:
www.healthfinder.gov

CDC Office on Smoking and Health:
www.healthfinder.gov/orgs/HR0049.htm

CDC Tobacco Information and Prevention Source:
www.cdc.gov/tobacco/

National Cancer Institute: www.cancer.gov

EPA Environmental Tobacco Smoke: www.epa.gov/iaq/ets/

Canada's National Clearinghouse on Tobacco and Health:
www.ncth.ca/NCTHweb.nsf

World Health Organization: www.who.int/en/

QuitNet: www.quitnet.com
Launched in 1995, QuitNet is a Web-based smoking cessation and resource forum funded by Massachusetts Tobacco Control Program.

National Spit Tobacco Education Program: www.nstep.org
Founded in 1994, NSTEP is an effort to educate the American public about the dangers of smokeless or spit tobacco.

Campaign for Tobacco-Free Kids' Kick Butts Day: http://kickbuttsday.org/
Kick Butts Day is an annual initiative that encourages activism and leadership among elementary, middle and high school students.

Sites That Target Specific Populations:
Ethnic/Racial Groups
Native CIRCLE: www.mayo.edu/nativecircle/resources.html
The American Indian/Alaska Native Cancer Information Resource Center and Learning Exchange

Cross Cultural Health Care Program: www.xculture.org
Lists books, videos, articles, trainings on health issues of ethnic communities.

University of Washington Medical Center: depts.washington.edu/pfes/cultureclues.html
Tip sheets for clinicians designed to increase awareness about general concepts and preferences of patients from diverse cultures: Albanian, African American, Chinese, Korean, Latino, Russian, Vietnamese (not specific to tobacco).

Gay, Lesbian, Bisexual, Transgender People
Gay City Health Project: www.gaycity.org

Out and Free: www.ciggybutz.com/outandfree.html
To order the 44-page cessation booklet, *Out and Free: Sexual Minorities and Tobacco Addiction*

Appendix D: Additional Reading

Barker, Dianne, editor. "Maternal Smoking Cessation: A Cost Effective Strategy for Managed Care." *Tobacco Control*, Vol 9, Suppl 1, 160-164, 2000.

Brideau, DJ. "Using Nicotine Replacement Therapies." *Patient Care,* 31(15): 31-44, 1997.

Centers for Disease Control and Prevention (CDC). "Cigarette Smoking-attributable Mortality and Years of Potential Life Lost: United States, 1990." *Morbidity and Mortality Weekly Report*, 42, 645-649, 1993.

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